

validation is justified. If a change occurs, CMS notifies all affected providers and suppliers at least 90 days in advance of implementing the change.

(3) CMS revalidates enrollment information for ambulance service suppliers in accordance with § 410.41(c)(2) of this chapter (Requirements for ambulance suppliers), and DMEPOS suppliers renews enrollment in accordance with § 424.57(e) (Special payment rules for items furnished by DMEPOS suppliers and issuance of DMEPOS supplier billing numbers).

**§ 424.520 Additional provider and supplier requirements for enrolling and maintaining active enrollment status in the Medicare program.**

(a) *Certifying compliance.* CMS enrolls and maintains an active enrollment status for a provider or supplier when that provider or supplier certifies that it meets, and continues to meet, and CMS verifies that it meets, and continues to meet, all of the following requirements:

(1) Compliance with title XVIII of the Act and applicable Medicare regulations.

(2) Compliance with Federal and State licensure, certification and regulatory requirements, as required, based on the type of services or supplies the provider or supplier type will furnish and bill Medicare.

(3) Not employing or contracting with individuals or entities—

(i) Excluded from participation in any Federal health care programs, for the provision of items and services covered under the programs, in violation of section 1128A (a)(6) of the Act; or

(ii) Debarred by the General Services Administration (GSA) from any other Executive Branch procurement or non-procurement programs or activities, in accordance with the Federal Acquisition and Streamlining Act of 1994, and with the HHS Common Rule at 45 CFR part 76.

(b) *Reporting requirements.* Following enrollment, a provider or supplier must report to CMS any changes to the information furnished on the enrollment application and furnish supporting documentation within 90 calendar days of the change, with the exception of DMEPOS suppliers which are required

to report changes of information within 30 days as specified in § 424.57(c)(2), or a change of ownership or control of the provider or supplier that must also be reported within 30 calendar days. Failure to do so may result in the deactivation or revocation of the provider or supplier's Medicare billing privileges.

**§ 424.525 Rejection of a provider or supplier's enrollment application for Medicare enrollment.**

(a) *Reasons for rejection.* CMS may reject a provider or supplier's enrollment application for the following reasons:

(1) The provider or supplier fails to furnish complete information on the provider/supplier enrollment application within 60 calendar days from the date of the contractor request for the missing information.

(2) The provider or supplier fails to furnish all required supporting documentation within 60 calendar days of submitting the enrollment application.

(b) *Extension of 60-day period.* CMS, at its discretion, may choose to extend the 60-day period if CMS determines that the provider or supplier is actively working with CMS to resolve any outstanding issues.

(c) *Resubmission after rejection.* To enroll in Medicare and obtain Medicare billing privileges after notification of a rejected enrollment application, the provider or supplier must complete and submit a new enrollment application and submit all supporting documentation for CMS review and approval.

(d) *Additional review.* Enrollment applications that are rejected are not afforded appeal rights.

**§ 424.530 Denial of enrollment.**

(a) *Reasons for denial.* CMS may deny a provider's or supplier's enrollment in the Medicare program for the following reasons:

(1) *Compliance.* The provider or supplier at any time is found not to be in compliance with the Medicare enrollment requirements described in this section or on the applicable enrollment application to the type of provider or supplier enrolling, and has not submitted a plan of corrective action as outlined in part 488 of this chapter.

(2) *Provider or supplier conduct.* A provider, supplier, an owner, managing employee, an authorized or delegated official, medical director, supervising physician, or other health care personnel furnishing Medicare reimbursable services who is required to be reported on the enrollment application, in accordance with section 1862(e)(1) of the Act, is—

(i) Excluded from the Medicare, Medicaid and any other Federal health care programs, as defined in §1001.2 of this chapter, in accordance with section 1128, 1128A, 1156, 1842, 1862, 1867 or 1892 of the Act.

(ii) Debarred, suspended, or otherwise excluded from participating in any other Federal procurement or non-procurement activity in accordance with section 2455 of the Federal Acquisition Streamlining Act (FASA).

(3) *Felonies.* If within the 10 years preceding enrollment or revalidation of enrollment, the provider, supplier, or any owner of the provider or supplier, was convicted of a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries. CMS considers the severity of the underlying offense.

(i) Offenses include—(A) Felony crimes against persons, such as murder, rape, or assault, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions.

(B) Financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions.

(C) Any felony that placed the Medicare program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct).

(D) Any felonies outlined in section 1128 of the Act.

(ii) Denials based on felony convictions are for a period to be determined by the Secretary, but not less than 10 years from the date of conviction if the individual has been convicted on one previous occasion for one or more offenses.

(4) *False or misleading information.* The provider or supplier has submitted false or misleading information on the enrollment application to gain enrollment in the Medicare program. (Offenders may be referred to the Office of Inspector General for investigation and possible criminal, civil, or administrative sanctions.)

(5) *On-site review.* Upon on-site review or other reliable evidence, we determine that the provider or supplier is not operational, or is not meeting Medicare enrollment requirements to furnish Medicare covered items or services. Upon on-site review, CMS determines that—

(i) A Medicare Part A provider is no longer operational to furnish Medicare covered items or services, or the provider fails to satisfy any of the Medicare enrollment requirements.

(ii) A Medicare Part B supplier is no longer operational to furnish Medicare covered items or services, or the supplier has failed to satisfy any or all of the Medicare enrollment requirements, or has failed to furnish Medicare covered items or services as required by the statute or regulations.

(b) *Resubmission after denial.* A provider or supplier that is denied enrollment in the Medicare program cannot submit a new enrollment application until the following has occurred if the denial:

(1) Was not appealed, the provider or supplier may reapply after its appeal rights have lapsed.

(2) Was appealed, the provider or supplier may reapply after notification that the determination was upheld.

(c) *Reversal of denial.* If the denial was due to adverse activity (sanction, exclusion, debt, felony) of an owner, managing employee, an authorized or delegated official, medical director, supervising physician, or other health care personnel of the provider or supplier furnishing Medicare reimbursable services, the denial may be reversed if the provider or supplier terminates and submits proof that it has terminated its business relationship with that individual or organization within 30 days of the denial notification.

(d) *Additional review.* When a provider or supplier is denied enrollment in Medicare, CMS automatically reviews

all other related Medicare enrollment files that the denied provider or supplier has an association with (for example, as an owner or managing employee) to determine if the denial warrants an adverse action of the associated Medicare provider or supplier.

(e) *Effective date of denial.* Denial becomes effective within 30 days of the initial denial notification.

**§ 424.535 Revocation of enrollment and billing privileges in the Medicare program.**

(a) *Reasons for revocation.* CMS may revoke a currently enrolled provider or supplier's Medicare billing privileges and any corresponding provider agreement or supplier agreement for the following reasons:

(1) *Noncompliance.* The provider or supplier is determined not to be in compliance with the enrollment requirements described in this section or in the enrollment application applicable for its provider or supplier type and has not submitted a plan of corrective action as outlined in part 488 of this chapter. All providers and suppliers are granted an opportunity to correct the deficient compliance requirement prior to a final determination to revoke billing privileges.

(i) CMS may request additional documentation from the provider or supplier to determine compliance if adverse information is received or otherwise found concerning the provider or supplier.

(ii) Requested additional documentation must be submitted within 60 calendar days of request.

(2) *Provider or supplier conduct.* The provider or supplier, or any owner, managing employee, authorized or delegated official, medical director, supervising physician, or other health care personnel of the provider or supplier is—

(i) Excluded from the Medicare, Medicaid, and any other Federal health care program, as defined in §1001.2 of this chapter, in accordance with section 1128, 1128A, 1156, 1842, 1862, 1867 or 1892 of the Act.

(ii) Is debarred, suspended, or otherwise excluded from participating in any other Federal procurement or non-procurement program or activity in ac-

cordance with the FASA implementing regulations and the Department of Health and Human Services non-procurement common rule at 45 CFR part 76.

(3) *Felonies.* The provider, supplier, or any owner of the provider or supplier, within the 10 years preceding enrollment or revalidation of enrollment, was convicted of a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries.

(i) Offenses include—

(A) Felony crimes against persons, such as murder, rape, assault, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions.

(B) Financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions.

(C) Any felony that placed the Medicare program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct.

(D) Any felonies that would result in mandatory exclusion under section 1128(a) of the Act.

(ii) Denials based on felony convictions are for a period to be determined by the Secretary, but not less than 10 years from the date of conviction if the individual has been convicted on one previous occasion for one or more offenses.

(4) *False or misleading information.* The provider or supplier certified as “true” misleading or false information on the enrollment application to be enrolled or maintain enrollment in the Medicare program. (Offenders may be subject to either fines or imprisonment, or both, in accordance with current law and regulations.)

(5) *On-site review.* CMS determines, upon on-site review, that the provider or supplier is no longer operational to furnish Medicare covered items or services, or is not meeting Medicare enrollment requirements under statute or regulation to supervise treatment of, or to provide Medicare covered items or services for, Medicare patients.